Northern Virginia Regional Strategic Planning Project

Strategic Plan and Recommendations

Submitted to the Commissioner, Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

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Table of Contents

INTRODUCTION	1
1. REGIONAL PARTNERSHIP MISSION, VALUES STATEMENT, AND STRATEGIC DIRECTION	4
2. OVERVIEW OF REGIONAL PARTNERSHIP STRATEGIC PLAN	6
2-A. Recognition of Regional Partnership (Reinvestment) Accomplishments.	. 6
2-B. Brief Description of the Regional Partnership Strategic Planning Process and Its Participants	
3. SUMMARY OF THE REGIONAL PARTNERSHIP'S STRATEGIC ASSESSMENT	9
3-A. Brief Description of Constituent and Consumer Expectations with Documentation, where appropriate	. 9
3-B. Brief Description of Regional Partnership's SWOT	14
3-C. Brief Description of Any Emerging External Political, Economic, Social and Technological Trends	16
3-D. Brief Description of Opportunities for Achieving Operational Efficiencies and Cost Savings	
4. CRITICAL ISSUES FACING THE REGION	17
5. STRATEGIC GOALS, OBJECTIVES AND STRATEGIES	18
6. REGIONAL RECOMMENDATIONS FOR STATE-LEVEL ACTION	31
Appendix A - Summary Brochure	32
Appendix B - Regional Community Forum Brochure	34
Appendix C - Members of Work Groups	36
Appendix D - Psychiatric Beds as of April 2004	40

INTRODUCTION

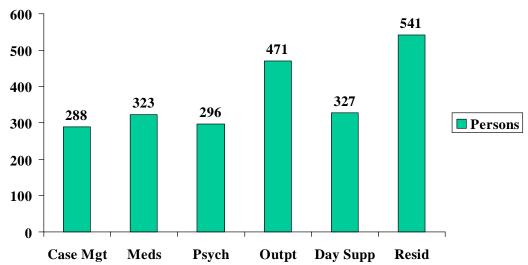
Northern Virginia lies across the river from the nation's capital. A large, diverse, cosmopolitan area of almost 2 million people, Northern Virginia is comprised of four counties and five cities and accounts for approximately 26% of the state's population. Of the five Northern Virginia community services boards (CSB), three serve single jurisdictions (Alexandra CSB, Arlington CSB, and Loudoun CSB). The other two, Fairfax-Falls Church and Prince William, are multi-jurisdictional boards. All five are administrative policy boards that enjoy close ties with their respective local governments. Two state facilities, Northern Virginia Mental Health Institute (NVMHI) and Northern Virginia Training Center (NVTC), are also located within Northern Virginia.

A hallmark of Northern Virginia is its rapid growth. Local Council of Governments projections estimate that the area will grow to 2.2 million residents by 2010. Even the more conservative state projections suggest that the area will approach 2 million persons by 2010. Whether one uses the local projection of 20.3% increase between 2000 and 2010 or the state projection of 13.7% for the same time period, Northern Virginia is projected to grow much faster than the state as a whole (where the most generous estimate of population growth for the same ten year period is 10.7%).

The area has rapidly become very diverse. In 1970, less than 10% of the residents in Northern Virginia were from racial or ethnic minorities. That figure grew dramatically by 2000 when more than 35% of the residents were classified as minorities. The 2000 Census also revealed that more than 21% of Northern Virginians are immigrants to America.

Although similar strategic planning efforts are taking place across the state, planning in Northern Virginia occurs against a backdrop much different from other parts of Virginia. Recognizing these differences, the Steering Committee decided at the beginning of the process that it would focus on adult mental health services with special emphasis on persons with serious mental illness. Although it broadened is scope somewhat in its second year, the Northern Virginia Regional Strategic Partnership Planning for Behavioral Health and Mental Retardation Services (NVRSPP) continued to concentrate its efforts on adult mental health services and the concomitant issues related to inpatient services, forensics, not guilty by reason of insanity (NGRI), co-occurring disorders and other significant concerns. The NVRSPP eagerly embraced the opportunity to convene groups where many different voices could express ideas.

Figure 1. Unmet Mental Health Service Needs



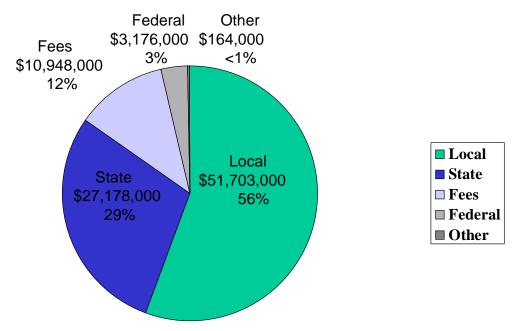
Source: Regional Submission to DMHMRSAS Comprehensive Plan 2004-2010

In its last submission to the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) Comprehensive Plan, the Northern Virginia region CSBs identified hundreds of persons waiting for mental health services. As shown in Figure 1,

- 541 were awaiting residential services.
- 471 were waiting for outpatient services.
- Over 300 persons were in need of medication services.
- Large numbers of persons were waiting for case management, day support and psychiatric services.

With close relationships to their county/city governments, the Northern Virginia CSBs benefit from significant local government funding. Over half (56%) of their funds for mental health services come from local sources, while another 29% is state funding. The balance of the funding for mental health services (15%) comes from a combination of client fees (Medicaid, Medicare, private insurance and client reimbursement), federal grants and miscellaneous sources, as displayed in Figure 2.

Figure 2. Funding for Community
Mental Health Services



State funding includes General Fund, DAD and State Pharmacy.

Balancing the appearance of abundance is the fact that:

- Millions of dollars of services were lost to cuts in State and local funding over the last several years.
- Virginia makes minimal use of Medicaid compared to most states.
- Inadequate reimbursement of Medicaid vendors has forced many to curtail services.

In this report the NVRSPP identifies several issues that impact mental health service delivery, summarizes the accomplishments of the NVRSPP, offers recommendations that will improve service delivery, and describes its intentions for its on-going planning. Prior to its June 2004 Community Forum, the NVRSPP created and widely distributed two documents to assist citizens to become familiar with the 2003 report and with current issues. These are included in this report as Appendix A, "Northern Virginia Regional Partnership Planning Project: Summary of Year One" and Appendix B, "Regional Community Forum of Mental Health Services in Northern Virginia."

1. REGIONAL PARTNERSHIP MISSION, VALUES STATEMENT, AND STRATEGIC DIRECTION

Central to the NVRSPP planning process are consumers -- their wishes to receive services in their own community, to be empowered to determine the type of services and service providers available to them, and to be accepted as productive citizens within their neighborhoods. With this in mind, the NVRSPP developed its own mission, vision and values statements to guide its planning for mental health, mental retardation and substance abuse services. It also adopted its own strategic direction specific to mental health services for adults.

Mission

The mission of the NVRSPP is to plan for an array of community-based and inpatient services.

Vision Statement

Development of a cost-effective, comprehensive, culturally competent array of recovery oriented, consumer choice driven, integrated services that are flexible, accessible and readily available to consumers and oriented toward proactive care, maintaining stability, and maximizing independent and community integration. Education must be intensified to combat and overcome discrimination historically associated with mental illness.

Values

The core values of the NVRSPP are consumer empowerment and consumer-centered service planning; in addition the NVRSPP supports recovery principles for persons with mental illness.

Strategic Direction for Mental Health Services

The NVRSPP strategic direction for mental health services includes:

- increase mental health community-based services to prevent psychiatric hospitalization or criminal diversion, whenever possible
- increase mental health community-based services to discharge hospitalized patients when they are ready for community services
- maintain the level and quality of inpatient services currently available to residents until better data on future demand is available
- implement recovery principles throughout the mental health service system
- provide readily available services.

2. OVERVIEW OF REGIONAL PARTNERSHIP STRATEGIC PLAN

2-A. Recognition of Regional Partnership (Reinvestment) Accomplishments

In its "Initial Report to the Commissioner," submitted in August 2003, the NVRSPP recommended that no reinvestment take place between the NVMHI and the Northern Virginia CSBs. It did, however, support the immediate transfer of \$2.5 million in State funds for the Discharge Assistance and Diversion (DAD) project from NVMHI to CSBs to purchase short-term inpatient psychiatric care in the private sector and to provide discharge assistance. The NVRSPP pointed out that the transfer of funds and the fiscal agent responsibilities to a CSB were consistent with the Governor's Reinvestment Initiative. The transfer was desirable for several reasons:

- It would maintain the current collaborative structure of the DAD project, which includes all of the CSBs, NVMHI and DMHMRSAS.
- It would provide even greater flexibility in how the funds can be used without shifting any additional responsibility for providing inpatient services to CSBs.
- Project funds would also be used to cover related administrative services.

In collaboration with DMHMRSAS, this transfer of funds and responsibilities was achieved in June 2004.

In addition to the reinvestment strategy mentioned above, the NVRSPP through its various work groups (described in the next section) was instrumental in other planning efforts, including:

- 1. The Mental Health Work Group collected and analyzed data to describe trends and to support planning recommendations.
- 2. NVMHI created a model to describe the levels of treatment needed by patients in public and private hospitals serving Northern Virginia. Both public and private providers of inpatient psychiatric services then applied this model to describe a patient's service needs.
- 3. The co-chairs of the Planning Process facilitated a dialogue among public and private sector inpatient hospital providers that further improved coordination and communication among public and private providers. For example, these discussions provide a venue to develop a more comprehensive understanding of inpatient services and associated challenges for the region.
- The Steering Committee reviewed evidence that the number of persons with no health insurance or inadequate coverage for psychiatric care is large and may be increasing.
 - Many indigent people are ineligible for Medicaid because of Virginia's restrictive eligibility requirements.
 - Most of the 28% of persons who are uninsured are probably treated as charity care by private hospitals.
- 5. Following a discussion of employment needs of persons with serious mental illness, the Steering Committee endorsed a federal WorkFORCE grant

- application submitted by vaACCSES in collaboration with several state and regional agencies. Unfortunately, the proposal was not funded.
- 6. Led by the Structural Work Group, the Steering Committee and its other work groups identified several statewide policies issues.
- 7. In preparation for the continuation of this process, the work groups identified a number of issues to be considered in the next planning phase. The Steering Committee has concluded that no beds should be closed at NVMHI at this time. This recommendation was based on anticipated population growth through 2010 and the proposed reduction of private sector psychiatric beds for adults in Northern Virginia

2-B. Brief Description of the Regional Partnership Strategic Planning Process and Its Participants

Demonstrating its intention to enhance collaborative planning throughout the area, the Northern Virginia Regional Partnership Planning Project began in December 2002. Since its inception this planning efforts has been co-chaired by the Executive Director of the Fairfax-Falls Church CSB and the Director of NVMHI. It includes a broad representation of stakeholders: Board chairs and staff from the five Northern Virginia CSBs, directors and staff of NVMHI and NVTC, advocates from each of the service areas, consumers, and providers from the private sector.

Early on the Steering Committee determined that it would focus on adult mental health services with a special emphasis on persons with serious mental illness. To address a number of issues related to adult mental health services, several work groups have worked diligently during the first two years of this project and include:

- Steering Committee that met monthly to guide the process of the planning effort and review its products.
- Mental Health Work Group, which addressed recovery principles; inpatient services; forensics and NGRI (Not Guilty by Reason of Insanity status); and co-occurring mental illness/substance abuse disorders. Two other groups that were already in existence contributed to the process, as well: one elaborated on issues facing older adults with mental illness or with dementia and the other addressed co-occurring mental retardation/mental illness issues. Next year, a work group will also address issues related to children's mental health services in the area.
- Structural Work Group that reviewed the overall structure that supports mental health services in Northern Virginia
- Private Hospital Work Group that met to discuss issues common to both public and private psychiatric hospital services
- Separate work groups that began addressing common issues involved in quality assurance/quality improvement; training; and information technology.

While the first two years of this planning process focused intensively on regional efforts, the Northern Virginia Regional Partnership Planning Project was also represented on

the statewide Restructuring Policy Advisory Committee. As is evident, several individuals and organizations participated in the region's planning process, some as one-time contributors and others as active members of work groups. The partnership, as structured in the first two years, is shown in Figure 1 below. Committee members are listed in Appendix C.

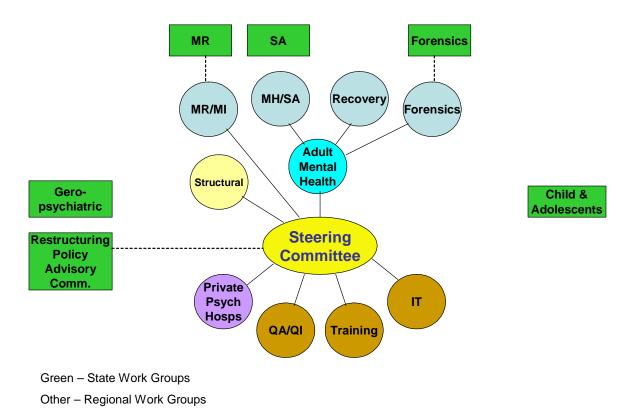


Figure 1. Northern Virginia Regional Partnership Planning Project

Current Structure (2003/2004)

To augment the experience and knowledge that members of the various committees and work group brought to this planning efforts, the Northern Virginia Regional Partnership Planning Project held 14 separate community forums and consumer focus groups in the spring of 2003 and convened a regional community forum and 6 additional focus groups in the summer of 2004. Data from these community forums and consumer focus groups assisted the Steering Committee in determining the direction for this planning effort and helped to shape both the 2003 and 2004 reports to the DMHMRSAS.

3. SUMMARY OF THE REGIONAL PARTNERSHIP'S STRATEGIC ASSESSMENT

3-A. Brief Description of Constituent and Consumer Expectations with Documentation, where appropriate

- Quality, appropriateness, responsiveness of services and supports delivered by the CSBs, state facilities and other providers
- Consumer and family member satisfaction with services and supports provided by or through the CSBs, state facilities, and other providers and the availability of choice among providers
- Extent to which consumers and family members have had meaningful involvement in Regional Partnership strategic planning

Northern Virginia used several mechanisms to learn about constituent and consumer expectations. To gain the broadest input, Northern Virginia conducted focus groups and community forums and encouraged broad participation on its Steering Committee and work groups. In addition, the responses from 1,245 consumers who answered survey questions for DMHMRSAS' 2003 Adult Mental Health and Substance Abuse Outpatient Consumer Surveys provide valuable information about consumer satisfaction with services. The Steering Committee members, representing consumers, advocates, CSBs, state facilities, private sector inpatient and community providers, and specific disability areas, also contributed their observations and expertise. While no single approach can completely portray the sentiments of constituents and consumers, these combined efforts allow Northern Virginia to tap several perspectives for service satisfaction and potential areas for improvements.

Constrained by a lack of resources to conduct a more extensive program review, DMHMRSAS offered its eighth annual survey to any outpatient consumer who received non-emergency outpatient services during one week in September 2003. The 23-item survey is a version of the Consumer Survey developed for the federal Mental Health Statistics Improvement Programs (MHSIP) "Consumer-Oriented Mental Health Report Card." The response rate for this survey at the five Northern Virginia CSBs ranged from 34% at one CSB to 88% at another.

In spite of its limitations, the survey provides a general indication of satisfaction among consumers who are receiving services from a Northern Virginia CSB. The responses are organized according to the way a respondent classified himself: 1) as receiving mental health services, 2) as receiving substance abuse services, or 3) as receiving mental health and substance abuse services. All three categories of consumers who responded to the survey expressed a relatively high level of satisfaction with the appropriateness of the services they receive, ranging from 86% to 92%. All three categories of consumers indicated general satisfaction with access to those services, ranging from 79% to 81% satisfied. Consumers who have both mental health and substance abuse problems indicated a relatively high level of satisfaction with all four domains that were measured: appropriateness (92 %), access (81%), outcomes (83%) and general satisfaction (90%). On the other hand, adults who receive mental health outpatient services appear to be substantially satisfied with appropriateness of (86%)

and access to services (81%) but less satisfied with outcomes related to the services they received (71%). The survey results for Northern Virginia are displayed in Table 1."

TABLE 1
Percent of Northern Virginia CSB-MHSIP Respondents
Who Report Satisfaction with:

	MH Adult OP ¹	SA Adult OP ²	MH/SA Adult OP ¹
Appropriateness	85.77%	86.01%	91.56%
	(N=513)	(N=540)	(N=179)
Access	80.93%	79.03%	81.00%
	(N=517)	(N=548)	(N=179)
Outcome	71.02%	84.21%	82.72%
	(N=509)	(N=532)	(N=177)
General Satisfaction	NA	78.55%	90.19%
		(N=540)	(N=180)

¹Includes responses from Alexandria, Arlington, Fairfax-Falls Church, Loudoun and Prince William CSBs

²Includes responses from Alexandria, Arlington, Fairfax-Falls Church, and Prince William CSBs

Source: DMHMRSAS Consumer Survey 2003 Annual Report

In preparing their responses to this section of the Plan, the Steering Committee reviewed all the input available to them – responses from over 130 consumers who participated in focus groups at the CSBs and NVMHI this year, approximately 60 people who participated in the community forum, various reports and the DMHMRSAS survey – and augmented these observations with their own knowledge and experience. The consumer and constituent expectations are presented in terms of satisfaction and dissatisfaction with the quality, appropriateness and responsiveness of services. After addressing these concerns, Northern Virginia offers several suggestions for changes that would improve services delivery. Some of the suggestions are offered to policymakers and others are general recommendations, followed by a series of additional consumer comments expressing gratitude and concern. This section ends with concerns expressed by patients at the NVMHI who are anticipating eventual discharge from the psychiatric hospital.

Responses from Consumer Focus Groups and Community Forum

Satisfied with quality, appropriateness, responsiveness:

- Positive attitude
- Gaining a sense of dignity
- Allowed to function in productive manner
- Staff, including case managers, counselors and therapists
- Specific program components, including case management, medication, groups, recreation activities, dual diagnosis groups, transitional services
- Employment services, including integration with Department of Rehabilitation Services (DRS), job coaching.
- Peer support and consumer run groups
- Assistance with bills
- Housing, "a place to come and be off the streets", including specifics on housing and transitional housing
- Positive comments about accessibility, included the coordination by staff and planning done to anticipate needs.

Not satisfied with quality, appropriateness, responsiveness:

- Discouraging attitudes from peers
- Waiting times
- Counselors being too busy, running late
- Losing caring staff
- Insufficient staff
- Not enough reminders- about medications, program orientations
- Lack of specific types of groups or approaches, such as groups for suicide survivors
- Limiting transition group
- Billing explanations
- Scheduling of services that present problems- with block scheduling, knowing
 when to bring up issues that are important, services not available on the
 weekends, doctors not always available to call back, hard to get rescheduled if
 you miss a medication appointment
- Transportation problems
- Waiting lists for service
- Sometimes treated differently based on where you live or your past history
- Concern over closing of INOVA Psychiatric Unit
- Need for more crisis care facilities to avoid hospitalization
- Too many transitions between hospital and doctors
- Treated differently when emergency rooms see you are on medication
- Insurance that does not cover private hospital, lack of public beds, not getting care
- Focus that is on getting out of the hospital, not getting well

Responses from Consumer Focus Groups and Community Forum (continued)

Important Messages to Convey to Policymakers:

- Need community organizations to respond to mental illnesses churches and more.
- Need to break down stereotypes
- Need to change attitudes of employees -- private/public
- Need more case managers, help with housing, benefits, appointments
- Explore funding, corporate and state tax incentives on housing
- Increase partnership planning, using a regional cooperation and partnership model
- Involve consumers much earlier in the process
- Need to have research-based practices (services) available in our communities
- Need to address barriers expand to state, profit/non-profit
- Need more action "Let's do something creative" (not just planning)
- Send people & the message to the Commissioner. It is a battle and a fight.
- "Look before you leap"
- Pay now or pay more later!

Recommendations:

- Staff: hire more; hire those with special expertise; hire staff who care; decrease caseload of staff; and increase time spent with counselors
- Housing: increase availability, staff, and accessibility
- Financial: more money from the state to support services, more funds to support job skill training and college
- Employment: training on how to work a job; help people return to work; hire employment specialists
- Activities: more social activities and opportunities to have fun
- Transportation: additional resources, make bus tokens available
- Services: duplicate program components that work; offer consumer/survivor run programs; consumer driven services; adequate support system for people transitioning to other programs; resource manual; keep the psychiatric unit at Inova open
- Approach: improve quantity and flow of information; decrease wait; "Treat everyone how we want to be treated;" believe that people can get better

Responses from Consumer Focus Groups and Community Forum (continued)

Additional Comments:

- Appreciation for seeking suggestions from consumers
- Appreciation for specific programs
- Concern about budget
- Staff and consumers need recovery training
- No seclusion without being told why
- "Help needs to come before it's too late"
- Respect is getting better

Comments from the consumer focus group held at NVMHI convey the concerns of persons who are hospitalized and trying to become well enough to be discharged to the community. They talked about their need for better services to help with their transition back to the community upon discharge from the hospital. They want to leave but they anticipate having difficulty "adapting" to the real world and the different expectations the community has for them. When they are in the community, discharged patients have to deal with neighbors, co-workers, and others who do not understand mental illness and will walk away when they hear that the patient was in the hospital. As expressed by the patients, "In the hospital you know everyone here has mental illness. . .similar to you. When in the community, that's not the case. So the average person in the community is more judgmental."

The NVMHI patients offered some ways that bridge the gap when transitioning to community:

- (1) May need adjustment in medications to get "over the hump"
- (2) Service providers, including psychiatrists who will work with you and listen to you when discussing the transition and what is needed to make the adjustment
- (3) Support groups in the area, specific focus and general, to have others around that understand what you are going through
- (4) Support groups for families, too (They also have to deal with the neighbors.)
- (5) An "in-between place/service/ treatment" that keeps you from having to go back to hospital if you are having trouble dealing with the transition. "Without this, you may end up feeling that you have to make a call re: feeling suicidal or stopping meds in order to get back to the hospital and an environment where you feel more comfortable."

3-B. Brief Description of Regional Partnership's SWOT

Based on information gleaned from surveys, focus groups, public hearings, and extensive experience in service provision, the Steering Committee developed a SWOT analysis, assessing Region IV's <u>S</u>trengths, <u>W</u>eaknesses, <u>O</u>pportunities and <u>T</u>hreats. Responses in each segment of this analysis are categorized to help the reader understand the uniqueness of Northern Virginia.

Strengths:

- Regional collaboration (CSBs and NVMHI)
- Quality of services
- Collaboration between and across public and private sector
- Level of local funding
- Collaboration and joint planning with local jurisdictions
- History of innovation and success
- Skilled work force
- NVMHI leadership in minimizing and managing behavioral emergencies without seclusion and restraint

Weaknesses:

- Difficulty locating private beds for persons who need psychiatric hospitalizations
- Future lack of private beds
- Beds that are empty because accepting physicians (for admission to hospitals) may not have opening in own caseload and may not have anywhere to refer the discharged person after hospitalization
- Beds that may be available but not accessible
- Limited applications of Evidence-Based Practices
- Limited consumer-run programs
- Limited opportunities to access federal funding
- Lack of resources around employment that should be explored further since different people have different experiences with this issue
- Variation in clinical capacity between the public and private sectors
- Variation in ability to manage people with challenging behaviors due to staff expertise or staffing complement differences between public and private sectors
- Variation in the administration of human rights between the public and private sectors
- Private hospital concern about lack of discharge planning
- Children and Youth:
 - Shortage of beds
 - Need to increase collaboration with mental health system regionally to develop special programs

- Lack of transitional services for youth with emotional disturbances who require continuing service from adult mental health programs
- Lack of ready access to mental health treatment in the jail regardless of the type of charge that the consumer faces
- Lack of integration of services with local HMO (Magellan)
- Impact of person from out of the region who seek services in Northern Virginia
- Lack of consumer choice
- Lack of knowledge for many people who do not know that consumers with mental retardation can also have mental illness
- Potential lack of system capacity to care for persons with mental retardation and mental illness
- Inability of State facility funding to keep up with rising drug, utility and medical costs
- Noncompetitive State worker's salary compensation, where average salaries for NVMHI positions are at least 20% below comparable positions in the Washington Metro area.

Opportunities:

- Grants
- Regional Recovery Forum, scheduled for September 2004
- Expanded capacity to provide culturally competent services
- Greater involvement of consumer graduates of CELT training
- Closer collaboration with the Department of Rehabilitative Services and better education of consumers and staff about vocational services
- Electronic transfer of discharge planning information between NVMHI and CSBs (in planning stage)
- Proposed establishment of an NVMHI Center of Excellence

Threats or Challenges

- Rising cost of medications
- Eroding infrastructure
- Population growth
- Lack of affordable housing
- Lack of transportation
- Lack of linguistic services
- Aging population with co-morbid disabilities
- Private bed shortage
- Growing forensics population
- Persons with MH inappropriately in jail (junk charges)
- Work force issues for public, private and non-profit sectors
- Definition of regional boundaries complicates service delivery

3-C. Brief Description of Any Emerging External Political, Economic, Social and Technological Trends

Northern Virginia, as other areas of the State, is experiencing several trends that may significantly impact service delivery. These are listed below:

Political:

Consumer activism

Economic:

- Lack of affordable housing
- Increasing number of uninsured persons
- Work force issues including critical shortages in key areas; public sector salary compression; average facility salaries for most roles ranging from 20% - 40% below average Metro salaries
- Increasing cost of medications
- Medicaid eligibility remains at 80% of federal poverty level
- Consumer employment issues, including cost of living and minimum wage
- Level of competition for qualified workers
- Exploration of increased use of non-profit sector/outsourcing
- Lack of Northern Virginia cost differential
- Lack of Medicaid rates to cover inflation
- Significant number of persons who could be cared for by Medicaid are not receiving services
- Public advertising of mental health conditions, e.g., depression, has increased public awareness for need for services but service capacity has not expanded to meet the increased demand for mental health and substance abuse services
- Increased demand for mental health services created by Mental Retardation Medicaid Waiver expansion and population growth
- Higher level of anxiety and awareness due to terrorist threats, e.g., attack on Pentagon, anthrax, sniper
- Stigma and prejudice from having mental illness and/or being a forensics patient and/or NGRI
- Traffic congestion that will affect the location of programs and cost of doing business
- Growing aging population with co-morbid medical conditions
- Increase number in criminal justice system
- Growing awareness that persons with mental retardation may also have mental illness and/or substance abuse problems.

Technological:

- Medical advances, e.g., neuro-scientific medical breakthroughs
- Automation of consumer/patient records
- Health industry error reduction strategies

3-D. Brief Description of Opportunities for Achieving Operational Efficiencies and Cost Savings

After reviewing the information available to it, the Steering Committee identified the following opportunities for efficiencies and cost savings:

Operational efficiencies that may be achieved by enhancing collaboration among public and private providers in the following areas:

- Information technology
- Training
- Quality Assurance/Quality Improvement
- Discharge planning
- Waiver infrastructure

Cost savings:

- Reducing staff travel time through greater use of video conferencing and electronically shared records (Note: Code change may be needed to allow greater use of video conferencing for detention and commitment hearings.)
- Explore public-private partnerships (community, hospital) for cost-effectiveness; recognize that setting impacts costs -- sometimes public is high, sometimes private is high; need to cover costs (including marginal costs) for private providers
- Explore new paradigm for public-private partnerships required by economic realities that cost variations in either sector are complex and interrelated.

4. CRITICAL ISSUES FACING THE REGION

The Steering Committee identified the following critical regional issues but did not place them in priority order.

- Declining number of private sector inpatient hospital beds
- Reduced NVMHI budget resulting in eroded infrastructure, i.e., NVMHI is not budgeted to meet rising costs, especially in the areas of drugs, utilities and competitive hiring
- Linguistic and cultural diversity issues
- Lack of affordable housing
- Availability and costs of medications
- Work force issues, especially nursing and psychiatry; noncompetitive facility salaries
- Traffic congestion will affect location of programs and cost of doing business.

5. STRATEGIC GOALS, OBJECTIVES AND STRATEGIES

Having identified several important issues affecting service delivery in Northern Virginia, the NVRSPP organized itself into work groups, as discussed previously. The accomplishments of the work groups, and for some their subcommittees, are presented here.

Adult Mental Health Work Group

At the heart of the NVRSPP is the Mental Health Work Group (MHWG), an overarching team that coordinates and directs the efforts to

- introduce Recovery principles throughout programs in the area
- understand the interrelationships of population growth, public and private psychiatric bed capacity and the types of patients who need inpatient services
- study the impact of forensics services on NVMHI and Western State Hospital (WSH)
- understand the prevalence of co-occurring disorders [Mental Health and Substance Abuse (MH/SA)] and offer recommendations for enhanced services for this special population
- recognize that persons with mental retardation may also have mental illness (MR/MI) and address service delivery issues for this special population.

Next year, the MHWG will add two other special populations to its charge:

- older adults with mental illness
- children and youth who have serious emotional disturbance.

In order to oversee its work, the MHWG invited consumers who receive services in the community and at NVMHI, advocates, representatives from mental health organizations, practitioners from the CSBs and NVMHI, non-profit programs and the private sector to join the work group. Meeting monthly, the MHWG has moved forward on many issues, including dissemination of information about Recovery; explanation of the impact of the forensic and not guilty by reason of insanity (NGRI) populations on NVMHI's census; and current and projected psychiatric bed capacity.

Recovery

Recovery principles are at the center of Northern Virginia's mental health planning and are becoming the cornerstone for service delivery. Championed by consumers, their families, friends and advocates and embraced by the five CSBs and NVMHI, the concepts of Recovery are helping to refocus public mental health practice in Northern Virginia.

- Recovery for persons with mental illness is a process nourished with hope.
- Recovery emphasizes the person, not the illness.
- Recovery is a process of living a satisfying life while managing a chronic mental illness.
- Recovery is not limited by the causes of mental illness.
- Recovery can occur even though symptoms may reoccur.
- Recovery asserts that individuals are responsible for the solution, not the problem.
- Recovery requires that the individual be supported by a system that
 - o includes consumers' rights and advocacy
 - recognizes the many dimensions of recovery.
- Recovery from severe psychiatric disabilities is achievable!

To help ensure that these principles are adopted throughout our service system, a group of consumers, families, friends, advocates and providers have joined forces to develop ways to move these ideas into practice. To accomplish this shift, the NVRSPP is planning a full-day conference on recovery to inform people about recovery principles and how the Northern Virginia mental health system can better support the recovery of individuals with mental illness.

The first Regional Recovery Conference is scheduled for September 14, 2004 at the Richard J. Ernst Community Cultural Center at Northern Virginia Community College in Annandale, Virginia.

Psychiatric Hospital Capacity and Utilization

Consumers and providers express significant concerns about the current and future adequacy of adult psychiatric hospital beds for Northern Virginia. As shown later in Table 2, the current occupancy rate ranges from 98% at the public hospital, NVMHI, to 59% at the area private hospitals. Although private hospital usage declined between 1990 - 2002, it has stabilized and no additional change is anticipated at this time. Given projected population growth and current usage rates, the overall occupancy rate for 2010 is projected to be 100.3%, an untenable situation.

TABLE 2 Current and Projected 2010 Occupancy Rates Adult Psychiatric Units

Northern Virginia Hospitals

		2004 Private			2010 Private	
	NVMHI ¹	Hospitals ²	Total	NVMHI ¹	Hospitals ³	Total
Average Daily Census	126.2	135.8	262	137.6	150.3	287.9
Number of Beds	129	232	381	129	158	287
Occupancy Rate	97.8%	58.9%	68.8%	106.7%	95.1%	100.3%

Sources: Data supplied by hospitals; calculations by Health Systems Agency of Northern Virginia staff

¹Northern Virginia Mental Health Institute

²Private hospital data are for 2003 and exclude 50 child and adolescent beds at Dominion Hospital and 20 adult beds at Virginia Hospital Center that are unavailable due to renovations

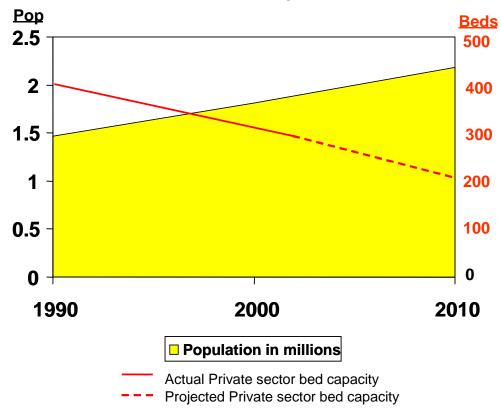
³Excludes the 40 bed child and adolescent unit at the proposed Broadlands Regional Medical Center

As Northern Virginia grows, the number of psychiatric inpatient beds in the area will probably decrease.

- Northern Virginia is growing twice as fast as the rest of the Commonwealth. From just over 1.8 million people in 2000, Northern Virginia is expected to grow by more than 20 percent by 2010 and will have 2.2 million residents.
- Area private hospitals are proposing to close 104 psychiatric inpatient beds.
 From their current combined capacity of 302 adult and children beds, the capacity within Northern Virginia private hospitals could be reduced to 198 beds in the future.
- Private providers, facing increased challenges in serving persons who have intense or complex service needs, are unable to serve some persons.
- The capacity at NVMHI remains at 129 beds. Most of the time NVMHI is full or near capacity.
- About 25% of the people at NVMHI could be served in the community if housing and integrated services were available, freeing beds for others who need them.

The impact of the projected population growth and reduced private sector psychiatric beds is shown graphically in Figure 2.

Figure 2. Actual and projected population of Northern Virginia and Private Sector actual and projected Psychiatric Bed Capacity for both adults and children and youth from 1990 to 2010



A variety of factors affect the private hospitals' decisions to close psychiatric beds, including financial losses, reductions in the number of psychiatrists willing to provide inpatient care, and low volumes of patients. General hospitals report significant financial losses in operation of their psychiatric units as a result of:

- Private insurance reimbursement, in adjusted dollars, has been reduced substantially and does not provide a significant margin
- More than a quarter of psychiatric patients are uninsured.
- Small volumes of patients in many hospitals do not enable hospitals to achieve economies of scale and results in higher costs per patient day.
- The high percentage of emergency psychiatric admissions results in sudden and substantial changes in volumes, making staffing and cost control difficult.

A large and increasing percentage of psychiatric patients in private hospitals have no insurance coverage for their hospitalization. In Northern Virginia, approximately 12% - 13% of the residents, about 250,000 persons, are estimated to be uninsured. Without funds to pay for services, many patients are treated as charity care -- which means that hospitals provide free service to low to moderate income, uninsured individuals and do not seek reimbursement. In 2002, 28% of psychiatric and substance abuse patients were uninsured for their hospitalization. Although some uninsured individuals have the

means to pay out-of-pocket for part or all of their inpatient psychiatric care, it is likely that most of the 28% who are uninsured are treated as charity care by the private hospitals. The high levels of charity care, combined with a relatively low percentage of persons who are privately insured, place significant strains on the financial operations of private hospital psychiatric services. In addition, some patients admitted to private hospitals and to NVMHI have no place to go upon discharge. As a result, their hospital stays are sometimes longer than necessary.

As psychiatric inpatient use has decreased at many facilities, the proportion of psychiatric patients who are emergency admissions has increased significantly. This presents operational challenges, as unanticipated admissions can quickly represent a substantial proportional increase in the number of patients on a unit. Many of the emergency psychiatric admissions are uninsured individuals. Not completely unrelated to the emergency situation, most of psychiatrists in both the public and private sectors do not maintain hospital privileges. Private psychiatrists can provide care in their offices and refer those patients needing hospitalization to another psychiatrist. This arrangement enables many psychiatrists to maintain a scheduled outpatient practice without having to follow their patients in the hospital and without having to be on call for emergency cases.

Contributing to the desire to place more publicly supported patients in the private hospital units is high occupancy of NVMHI. While use of private beds has decreased substantially since 1990, the Institute's beds operate at a very high occupancy, as seen in Table 2. This reflects both the demand for services resulting from civil commitment proceedings and the use of about one-fourth of the Institute's beds for persons found not guilty by reason of insanity (NGRI) through the criminal justice system. Not all NGRI individuals continue to need the level of care provided at NVMHI, but the Institute must keep them as long as directed to do so by the courts.

Local CSBs are interested in placing appropriate patients in the private sector. Unfortunately, even before the potential net loss of 94 adult and 10 children's beds, CSBs report frequently having difficulty placing patients in the private sector. (Please refer to Appendix D for details regarding private hospital capacity.) Although there have been many empty beds within the region, facilities contacted often report that they cannot accept the patient. Sometimes there is insufficient staff available. Other times, the hospital is unable to accept a patient with particular conditions or behaviors. Sometimes no psychiatrist is ready to accept the referral. Hospitals also are reluctant to accept patients when there is not an available placement for care after discharge. These and other factors can lead to many calls seeking placement, including to facilities outside Northern Virginia after local facilities have not provided care despite empty beds here. There is substantial concern that a sharp reduction in licensed psychiatric beds in the region may exacerbate these placement problems.

If use rates remain stable over the next six years, there will not be enough capacity to accommodate projected demand. Table 2 shows that, without further decreases in use rates, NVMHI would be above 107 percent occupancy and the private hospitals would

be above 95 percent. The projection of 31 to 38 more patients per day than could be readily accommodated may prove to be conservative. The projections are based on State population estimates and projections, which anticipate Northern Virginia adding about 30,000 persons per year between July 2003 and April 2010. Between the 2000 census and July 2003, the State estimates that Northern Virginia gained 50,000 persons annually. Should that rate of growth continue, the region could have 48 to 55 more patients a day than could readily be accommodated in 2010.

Clearly, if this increased need for psychiatric beds were to occur without expanded service capacity, patients would not be well served and would face waiting lists, delayed admissions, referrals outside the region, and denial of needed care. This potential lack of services could increase a patient's risk of becoming involved in the criminal justice system. Many of those affected would be persons detained or committed as part of legal proceedings. This places additional pressure on NVMHI, since the Commissioner is legally responsible for serving these individuals, even though a bed might not be available.

The projected need for additional capacity could be met by adding beds at NVMHI, adding beds in the private hospitals or by adding beds in both the public and private sector. Alternatively, community services and housing options could be developed to treat some individuals who are hospitalized now. These services would need to be intensive but could be economical and would promote earlier community reintegration.

The public and private sectors, including private hospitals, have worked cooperatively in Northern Virginia as part of the Partnership process. They have undertaken two detailed evaluations of all hospital psychiatric patients to characterize, among other things, the levels of care provided in each sector. Those two assessments, in September 2003 and March 2004, are summarized in Table 3. The distribution of patients among levels has been averaged and applied to the March 2003 counts of 130 patients at NVMHI and 150 patients in the private hospitals. The table shows that the private hospitals are more oriented towards acute stabilization and intensive care, while NVMHI is more focused on longer-term intermediate and rehabilitative care.

TABLE 3

Distribution of Adult Patients By Level of Inpatient Treatment September 2003 and March 2004

Northern Virginia Hospital Psychiatric Units

		Private	
	NVMHI ¹	Hospitals	Tota
Level I	5	59	64
Acute Stabilization: high acuity, low c	omplexity, expected stay 2-5 d	ays	
Level II	18	49	67
Intensive Care: high acuity, high com	plexity, expected stay <30 day	25	
Level III	48	34	82
Intermediate Care: variable acuity, hi	gh complexity, expected stay >	-30 days	
Level IV	59	8	67
Rehabilitative Services: low acuity, hi	gh complexity, expected stay >	30 days	
Total	130	150	280

Sources: Data supplied by hospitals; averaging of 2003 and 2004 data performed by staff of the Health Systems Agency of Northern Virginia.

¹Northern Virginia Mental Health Institute. The total of 130 patients reflects patients who were at NVMHI on different days during the survey week.

As can be seen in Table 3, almost half of NVMHI patients are persons receiving rehabilitative care, in Level IV. Some of those individuals could be treated outside the hospital if there were appropriate community resources available. Almost one-third of the Level IV patients at NVMHI have been placed there after having been found "not guilty by reason of insanity" (NGRI) through legal proceedings. Because the NGRI patients are placed through the courts, they cannot be released by NVMHI without court directive. The other 35 to 40 Level IV patients, however, could be evaluated for possible treatment and services outside NVMHI if there were resources in the community. (Note: It is unlikely that all 35 to 40 patients could be immediately treated in the community.) However, this number of persons approximates the projected number of people who could not readily be accommodated if the number of beds were as anticipated. The development of community resources, consequently, is an alternative to adding beds that could result in beds being used efficiently, the expense of developing new beds being avoided, and individuals being treated in the least restrictive appropriate setting.

Both the Mental Health Work Group and the Private Hospitals Work Group are reviewing options to meet the demand for inpatient care, including diversion of consumers to community programs, as well as increasing psychiatric bed capacity.

Forensics

In Northern Virginia, if a person with mental illness is arrested, he may receive some mental health services at the local jail, at Western State Hospital (WSH) or at NVMHI. The type and location of the mental health service depends upon the person's condition and whether the person has already been to trial.

Each year, some persons with mental illness are arrested and taken to local jails. Some receive mental health services in the local jail while awaiting trial or after being convicted. If, however, the individual's psychiatric symptoms are too severe, the person may be taken from the jail to WSH to receive treatment for a mental illness. Sometimes, too, an individual is sent to WSH for an evaluation of his ability to stand trial or of his state of mind at the time that the crime was committed. Following the evaluation and/or treatment, the individual is returned to the local jail. Last year, 142 people from the local jails in Northern Virginia received some type of mental health service from WSH.

Another group of people who become involved with both the criminal justice system and the public psychiatric hospitals are those Northern Virginia residents who have gone to trial for a crime and have been found Not Guilty by Reason of Insanity (NGRI). Following their trial, adjudication, and a period of evaluation at Central State Hospital, these individuals receive treatment for their mental illness at NVMHI. During treatment, the individual's progress toward recovery supports his ability to advance through a graduated release program. This program allows greater levels of hospital and community access, with less supervision, as the individual works toward community reintegration. The amount of time it takes a patient to move through this graduated program varies but typically exceeds one year and may take several years. The number of NGRI patients fluctuates between one-fifth and one-quarter of the patient population at NVMHI.

Concerned that such a large number of NVMHI beds were needed for NGRI patients, a forensics work group comprised of CSB and NVMHI staff as well as a NVMHI patient representative examined the reasons for the long length of stay and other issues related to the treatment of NGRI patients. Their work, along with comments from several NGRI patients at NVMHI, resulted in suggestions for education, training, and employment opportunities, as well as increased attention to substance abuse issues. One suggestion is to publish a workbook for all potential and current NGRI patients that explains the NGRI system, patient rights and their recourses in a quick and easy way.

Mental Illness and Substance Abuse

Understanding the prevalence and impact of substance abuse problems for persons with mental illness is the focus of the subcommittee for Co-occurring Disorders. The subcommittee addressing this issue is coordinating their work with the DMHMRSAS committee on Substance Abuse and Mental Illness. Members of this subcommittee have shared their local strategies to train staff to recognize both mental health and substance abuse problems, to plan individualized services that address both issues, and to implement an effective service delivery system.

Mental Retardation and Mental Illness

Guided by the work of the DMHMRSAS Statewide Dual Diagnosis Steering Committee, a regional subcommittee, comprised of mental retardation and mental health advocates and providers, is addressing the needs of individuals who have both mental retardation and mental illness. The charge of the regional subcommittee is similar to that of the statewide group:

"to engage in collaborative partnerships to develop state-ofthe-art services and supports for individuals who require care and treatment related to the co-occurrence of the conditions of mental retardation and mental illness. The partnership will seek to

- (1) identify the prevalence of this dual diagnosis
- (2) reduce barriers to treatment
- (3) identify best practices models
- (4) train service providers, consumers and families"

In its report of July 30, 2004, the Regional MR/MI (Mental Retardation/Mental Illness) Subcommittee offered details about:

- Current services critical to achieving a successful outcome
- Barriers and service enhancements that would increase successful outcomes
- Next steps and recommendations in the areas of system issues, treatment, education and training, and funding.

In exploring options for community services for this special population, the subcommittee is stressing the awareness and existence of dual diagnosis and the importance of parents and caretakers recognizing when dual diagnosis is a factor. To aid in this effort, the subcommittee is drafting an informational brochure that points out that:

 Recognition is important to obtaining appropriate treatment and services.

- Depression and anxiety are among the most common mental illnesses experienced by individuals with development disabilities.
- Personality and conduct disorders such as schizophrenia, mania, dementia, and Alzheimer's are also seen in individuals with developmental disabilities.
- Some behavioral problems, such as aggression or inappropriate sexual activity, may warrant a mental illness diagnosis, though challenging behaviors may also simply represent the lack of social skills or frustration of limited communication.

Efforts are underway to obtain funding to print the brochure so that it may be widely distributed to aid awareness and existence of dual diagnosis.

Private Psychiatric Hospitals

The major issues being addressed by the Private Psychiatric Hospital Work Group – the number of psychiatric inpatient beds available at any time and the types of patients who occupy those beds – has already been discussed above in the section for Psychiatric Hospital Capacity and Utilization. Established in March, 2003, this Work Group consists of representatives from eight private sector hospitals with a psychiatric unit and one freestanding psychiatric hospital in Northern Virginia. Representatives of the CSBs, MHWG and advocacy organizations join these members at regular meetings.

Among this past year's accomplishments is the analysis of data collected during the second application of the "Levels of Adult Inpatient Psychiatric Treatment" model to psychiatric patients at the nine hospitals. The analysis illustrated the differences in the primary roles of the public and private sectors: the private sector is more likely to offer services for short-term, acute or intensive care, while the public sector is more likely to provide long-term services for those persons requiring intermediate and rehabilitative care. In addition, the public sector has a substantial number of people who could receive services in the community if the community capacity were expanded and significant housing issues addressed.

The Work Group is also addressing several issues emanating from the proposed bed closures at some hospitals, including the use of private and public beds for temporary detention orders, the need to re-bid contracts, the continuity of care for patients discharged from private hospitals into the care of local CSBs, and the need for additional community-based resources.

Older Adults with Mental Illness

The Northern Virginia Alliance for Geriatric Mental Health Care continues to advocate for the availability of appropriate services in Northern Virginia for older adults who have mental illness. Their report was included as an Appendix to the NVRPPP's "Initial

Report to the Commissioner." To bring more visibility to the issues facing older adults as well as to plan for them to receive needed services in Northern Virginia, the NVRSPP recently established a work group to deal with concerns of this special population.

Child/Adolescent

As it broadens its scope next year, the NVRSPP will collaborate with the CSA (Comprehensive Services Act for youth and children) Coordinators and Community Planning and Management Teams of Northern Virginia to plan for mental health services for youth. Of particular interest to this committee are the mental health needs of foster care children and the needs of youth who are transitioning from children's services to adult mental health services. The committee will work closely with the Mental Health Work Group.

Administrative Infrastructure

Effective infrastructure contributes to the success of programs. Recognizing that some efficiencies may be possible if regional cooperation were extended for some administrative processes, NVRSPP created three subcommittees: (1) for training; (2) for quality improvement; and (3) for information technology. Each of these subcommittees will continue to explore ways to work together more effectively on behalf of Northern Virginia's programs.

The proposal to create a Center for Excellence at NVMHI is an additional example of the administrative infrastructure project that is being pursued. The purpose of establishing such a Center would be to extend the thinking and practices that led to successful seclusion and restraint reduction at NVMHI into community based agencies. This would include public and private providers in residential and hospital settings.

Data reflect that NVMHI is below both national and southern region data in hours of restraint, percent of clients restrained, hours of seclusion and percent of clients secluded. The designation as a Center of Excellence would enable NVMHI to explore small grant funding to support regional initiatives that would foster consumer-provider relationships that are consistent with DMHMRSAS' vision for a recovery based system of care.

Next Steps

To assist the NVRSPP in defining its work for next year, the following questions were posed to participants of the 2004 Community Forum:

- (1) Has the mental health regional planning been meaningful and targeted to the right issues?
- (2) What should we do next with our partnership planning?

Participants offered the following suggestions in response to the questions:

Additional populations to include:

- Aging-up youth
- Youth with Serious Emotional Disturbance
- Older Adults
- Refugees

Programming to consider:

- Specialized programs for persons with co-occurring disorders (mental illness and substance abuse)
- Nursing homes for mentally ill consumers
- Family supports/ interventions
- Specialized treatment for personality disorders (such as DBT)
- More PACT and emergency services
- Teaching people how to live outside hospital

Approaches to use:

- Cost savings by partnering with regional organizations on training
- Promote involvement of consumers
- Focus on hospital and jail diversion
- Look at fundraising opportunities
- Regional coordination/cooperation especially around immigrant population
- Look at best practices for providing services that are up-to-date and contemporary
- Build on September 14, 2004 recovery training -- invite legislators and use the opportunity to educate them about needs
- Help develop the constituency for support -- involvement of consumers throughout the process, start targeting and give early support
- Increase utilization of Medicaid funding
- Strengthen respect
- Training for therapists/first responders for emergency mental health situations
- Crises prevention
- Keep listening
- Educate public for funding

Even two years is not enough time to plan for and solve most of the mental health issues. So, mental health planning will not end when this Report is sent to Richmond. Members of the NVRSPP, shown in Figure 3 below, will continue to offer insights and suggestions to improve mental health services.

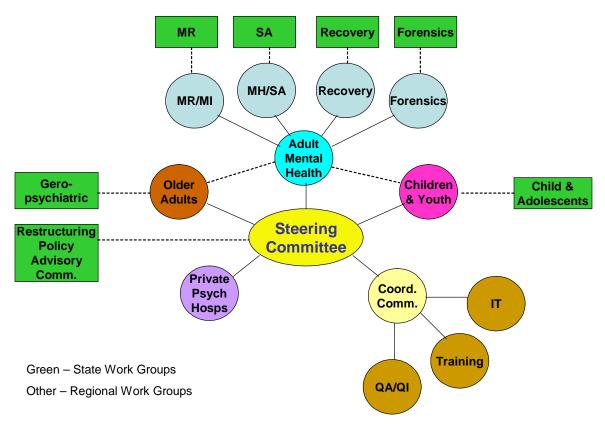


Figure 3. Northern Virginia Regional Strategic Planning Partnership

Proposed Structure (2004/2005)

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6. REGIONAL RECOMMENDATIONS FOR STATE-LEVEL ACTION

After reviewing the results of its work for the last two years, the NVRSPP offers the following recommendations for state-level action. These recommendations, some of which were offered in last year's report, represent some of the most important issues facing the Northern Virginia region, as well as the Commonwealth of Virginia.

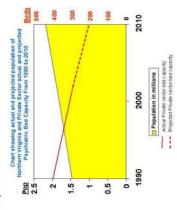
- Improve Virginia's Medicaid Assistance Plan by
 - o increasing eligibility level from 80% to 100% of federal poverty level
 - o setting rates at a level sufficient to cover costs of all Medicaid services
 - o expanding the array of services, e.g., PACT as a bundled service.
- Fully fund the entire continuum of care, including state facilities, private hospitals and community-based services.
- Foster greater use of private sector providers by ensuring that they are reimbursed adequately by all sources, including public payers such as Medicaid and DMHMRSAS as well as private insurance companies.
- Maintain an adequate capacity of psychiatric inpatient beds and communitybased services.
- Begin funding the recommendations contained in "One Community," the final report of the Olmstead Task Force.
- Maintain the current bed capacity at NVMHI in light of increasing population and proposed reductions in the number of beds in the private sector.
- Establish a Center for Excellence at NVMHI focused initially on sharing the approaches that have led to significant reductions in seclusion and restrain.
- Re-bid the State contract for inpatient psychiatric care to include the option of pre-purchasing beds.
- Actively promote the Recovery Principles throughout the Commonwealth.
- Reestablish an Office of Consumer and Family Affairs in DMHMRSAS.
- Establish and fund consumer empowerment training throughout the Commonwealth.
- Request that the State design and implement, in collaboration with the private sector, a system for properly addressing the growing need for services for older adults with mental illness and persons with dementia who have psychiatric symptoms.
- Request that DMHMRSAS carefully consider the recommendations from the regional work groups studying how to better serve persons with a dual diagnosis of mental illness and mental retardation.
- Coordinate regional and state service issues.
- Fully fund medications at State facilities and those provided through the State Aftercare Pharmacy for discharged state hospital and non-hospitalized consumers
- Identify educational materials needed for General Assembly.
- Implement consumer participation in policy and program levels.

Focus on Inpatient Care

- Northern Virginia had the lowest bed day utilization rate in the State,
- NVMHI with 127 beds had an occupancy rate of approximately 95%
- hospitalization and to discharge patients who completed a successful Northern Virginia made extensive use of Discharge and Diversion DAD)/Private Bed Hospitalization (PBP) funds to prevent
- "Level of Adult Inpatient Treatment Survey" was developed by NVMHI and administered to patients at NVMHI and nine private hospitals. Findings showed that:
- needed intermediate care or rehabilitative services, whose acuity is The private sector provided care primarily for patients who needed The public sector provided care mainly for long-term patients who low or variable, but whose service issues were complex.
 - high and whose service issues vary from low to high complexity. abuse patients served in the private hospitals does not have insurance short-term, acute stabilization or intensive care, whose acuity is A large and increasing percentage of the psychiatric and substance
 - uninsured for the services provided. Public funds covered some In 2002, 28% of psychiatric and substance abuse patients were coverage for their hospitalization.
 - services.
- Medicare covered 13%
- Medicaid accounted for 6%
- Other State or local programs covered 7%
- 1% had reimbursement provided by the military system.
 Northern Virginia had 224 private sector psychiatric beds and 127 1% had reimbursement provided by the military system
- Proposed Expansions = 40 beds

public sector (NVMHI) beds.

Proposed Closures = 120 beds



2003 Plan Recommendations for Mental Health Services for

- Improve Virginia's Medicaid Assistance Plan by:
- increasing eligibility level from 80% to 100% federal poverty level
 - setting rates at a level sufficient to cover costs of all Medicaid
- expanding the array of services, e.g. PACT as a bundled service
- Fully fund the entire continuum of community-based services.
- reimbursed adequately by all sources including public payers such as Foster greater use of private sector providers by ensuring that they are Medicaid and DMHMRSAS as well as private insurance companies for inpatient psychiatric care.
- population and proposed reductions in the number of beds in the private Maintain the current bed capacity of NVMHI in light of increasing
- Support immediate transfer of \$2.5 million in State funds for the DAD Project from NVMHI to CSBs. These funds will primarily be used to purchase short-term inpatient psychiatric care in the private sector
- Reestablish an Office of Consumer and Family Affairs in DMHMRSAS. Actively promote the Recovery Model throughout the Commonwealth
- Establish and fund consumer empowerment training throughout the
- Request that the State design, in collaboration with the private sector, a system for properly addressing the growing need for services for older adults with mental illness and persons with dementia who have
- from the regional work groups studying how to better serve persons with a dual diagnosis of mental illness and mental retardation Request that DMHMRSAS carefully consider the recommendations

Our Vision for Mental Health Services

Development of a cost-effective, comprehensive, culturally competent array of recovery oriented, consumer choice driven integrated services that are flexible stability, and maximizing independence and community integration. Education and accessible to consumers and oriented toward proactive care, maintaining must be intensified to combat and overcome discrimination historically associated with mental illness.

Partnership Planning Northern Virginia Regional Project

Summary of Year One

Northern Virginia for adults in need of mental The publicly funded system of services in health services through 2010 Initial Focus:

Virginia Department of Mental Health, Substance Abuse Services Mental Retardation and Submitted to

August 2003

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Consumers and Community Participate in Plan

Input from Six Community Forums

- MORE FUNDING for community-based services
- More inpatient diversion and discharge assistance services More regional approaches for specialize services
- Better services for homeless persons with Substance Abuse and Serious
- More education and support for families Better insurance coverage

 - Ensure access to medications
- More consumer-run programs, especially evenings, weekends, and social
 - network for consumers
- More PACT teams in region More public transportation
- Preserve accessibility to private psychiatric hospital beds
- Improve services in jails and more training for judicial system and public
- Gero-psychiatric services must be more available to residents of nursing homes and assisted living facilities as well as persons still living in their Establish an MH Medicaid Waiver

Input from Eight Consumer Focus Groups

- Jobs, housing and transportation to facilitate recovery
- More involvement of consumers and family members
- Recovery Model throughout the public and private systems of care
 - Support for educational goals

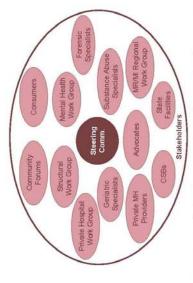
 - Importance of medications
- Access to regional specialists
- More time with psychiatrists for dialogue
- More respect for the perspective of consumers A range of vocational services and options
 - Long delays for service
- Technical assistance in applying for state and federal benefits
- Education about medications and easy access to professionals
 - Better access to grief counseling
- Continuity of care between jails and community
- More varied programs in club houses and group homes
- Better access to Internet in the hospital and in the community

Together Northern Virginia Plans for Mental Health Services for Adults

The Partnership involved many people who exchanged ideas about the mental health system in Northern Virginia. Members of the Partnership offered diverse perspectives on many significant issues, including:

- Recovery Principles
- Forensic and Not Guilty by Reason of Insanity
- Co-occurring Disorders (Mental Illness and Substance Abuse)
- Older Adults with Mental Illness
- Children and Adolescents
- Mental Retardation and Mental Illness
- Private Hospitals
- State Facilities
- Administration and Infrastructure

Several groups participated in the planning process, some as one-time contributors and others on standing committees. The comprehensive partnership is shown below.



Participants in the Northern Virginia Regional Partnership Planning Project

Achievements During 2003 Planning Period

- The Mental Health Work Group collected and analyzed data to describe trends and to support planning recommendations
- hospitals serving Northern Virginia. Both public and private providers of describe the levels of treatment needed by patients in public and private Northern Virginia Mental Health Institute created an instrument to inpatient psychiatric services used this instrument to describe their patients' needs. A follow-up survey is underway.
- The co-chairs of the Planning Process facilitated a dialogue among public and private sector inpatient hospital providers. è
- In collaboration with DMHMRSAS, the Steering Committee developed a Reinvestment Initiative to transfer about \$2.5 million in State funds from NVMHI to CSBs.

The process further improved coordination and communication among

- The Steering Committee reviewed evidence that the number of persons with no health insurance or inadequate coverage for psychiatric care is public and private providers, e.g., significantly reduced the number of persons on the extraordinary barriers to discharge list. large and may be increasing. 9
- Many indigent people are ineligible for Medicaid because of Virginia's restrictive eligibility
- Most of the 28% of persons who are uninsured are treated as charity care by private hospitals.
- mental illness, the Steering Committee endorsed a federal WorkFORCE grant application submitted by vaACCSES in collaboration with several Following discussion of employment needs of persons with serious state and regional agencies. (Not funded.) 7
- work groups identified several statewide policy issues to be presented to the Restructuring Policy Advisory Committee. Led by the Structural Work Group, the Steering Committee and its other
- identified a number of issues to be considered in the 2003-2004 planning In preparation for the continuation of this process, the work groups
- The Steering Committee has concluded that no beds should be closed at population growth through 2010 and the proposed reduction in private sector psychiatric beds for adults in Northern Virginia. NVMHI at this time. This recommendation is based on anticipated 10

Community Forum Agenda

10:00 a.m. Welcome

10:05 a.m. Presentation of Background and Issues

- Community-Based Services
- Inpatient Psychiatric Services
- Special Populations Recovery Principles
- Funding for Mental Health Services

10:45 a.m. Small Group Discussions

Toll ne

- Has the mental health regional planning been meaningful and targeted to the right issues?
- What should we do next with our partnership planning?
- planning? What is the most important message we can give to

our local and state governments? 11:45 a.m. Report out of Small Group Discussions

12:20 p.m. Next Steps

12:30 p.m. Adjourn

Special Populations

In March 2004, staff at nine private psychiatric hospitals and the Northern Virginia Mental Health Institute determined that about one-third of the private psychiatric hospital patients and just under a half of the public psychiatric patients had co-cocurning diagnoses. Most of the persons with dual diagnoses had both mental illness and substance abuse problems. A few had mental illness and mental retardation, while some others had mental illness, mental retardation and substance abuse problems. Simmet of co-occurring disorders (mental health and substance abuse) in consumers who receive outpatient services often approach 75 percent.

Because treatment is complicated when persons have dual diagnoses or are older adults with mental illness or children and adolescents with serious emotional disturbances, four work groups are addressing the needs of these special populations:

- Co-cocurring Disorders (Mental Illness and Substance Abuse)
- Mental Retardation and Mental IIIs
- Older Adults with Mental Illness
- Children and Youth with Severe Emotional Disturbances

Recovery

Recovery for persons with mental illness is a process nourished with hope.

- Recovery emphasizes the person, not the illness.
- Recovery is a process of living a satisfying life while managing a chronic mental illness.
- Recovery is not limited by the causes of mental illness.
- Recovery can occur even though symptoms may reoccur.
- Recovery asserts that individuals are responsible for the solution, not the problem.
- Recovery requires that the individual be supported by a system that
 - includes consumers' rights and advocacy, and
- recognizes the many dimensions of recovery.
- Recovery from severe psychiatric disabilities is achievable!

Recovery Principles are at the center of Northern Virginia's mental health planning and are becoming the cornerstone for service delivery. Champtorned by consumers, their families, friends, and advocates and embraced by the five CSBs and NVMHI, the concepts of Recovery are helping to refocus public mental health practice in Northern Virginia.

To help ensure that these Principles are adopted throughout our service system, a group of consumers, families, firends, advocates and providers have joined forces to develop ways to move these ideas into practice. To accomplish this shift, we are planning a full-day conference on recovery principles. Join us to learn more about recovery principles and how our mental health system can better support the recovery of individuals with mental lillness.

Also Plan to Attend:

First Regional Recovery Conference

fuesday, September 14, 2004

Richard J. Ernst Community Cultural Center at Northern Virginia Community College Annandale, Virginia For more information on the conference, please visit us online at www.fairfaxcounty.gov/service/csb/region/partnershipmain.htm - information will be posted as it becomes available.

You are needed! Help plan our system of mental health services through 2010.

Regional Community Forum on Mental Health Services in Northern Virginia

Saturday, June 26, 2004

10:00 a.m. - 12:30 p.m. Refreshments will be served at 9:30 a.m.

Fairfax County Government Center 12000 Government Center Parkway, Fairfax

Language interpreter services, transportation assistance and other special accommodations are available upon request.

To request these services, call Lara Larson at 703-324-7027 or e-mail Lara.Larson@fairfaxcounty.gov

Strategic Planning for Community-Based Mental Health Services in Northern Virginia

community forum to discuss mental health issues and obtain community comments process to plan for improved community-based mental health services in Northern Consumers, family members, advocates and providers are completing a two-year prior to submitting a plan to the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) in August. Virginia. On June 26, the Northern Virginia Planning Partnership will hold a

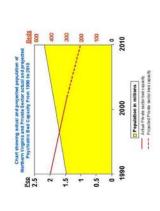
Many issues are being addressed:

- The need to increase community-based services to prevent psychiatric hospitalizations whenever possible
- Strategies to discharge hospitalized patients when they are ready for community services
- The decreasing number of psychiatric inpatient beds that are available to area residents
- Implementation of Recovery principles at community services boards (CSBs) and at the Northern Virginia Mental Health Institute.
- Services for forensic patients and those who are found Not Guilty by
- Reason of Insanity
- Mutual issues related to public and private psychiatric hospitals.
 - Service needs of special populations:
- Older Adults who also have mental illness
- Children and Youth who have a serious emotional disturbance Persons who have both mental illness and substance abuse problems 0000
 - Persons with mental retardation who also have mental illness

Even two years is not enough time to plan for and solve most of the mental health issues. So, mental health planning will not end when this Report is sent to DMHMRSAS. Members of the Partnership, shown below, will continue to offer insights and suggestions to improve mental health services



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Psychiatric Inpatient Beds

As Northern Virginia grows, the number of psychiatric inpatient beds in the area will probably decrease

- Northern Virginia is growing twice as fast as the rest of the Commonwealth. From just over 1.8 million people in 2000, Northern Virginia is expected to grow by 20 percent by 2010 and will have 2.1 million residents.
- Area private hospitals are proposing to close over 101 psychiatric inpatient beds, re-open 20 beds, and add 7 beds. From their current combined maximum capacity of 230 private adult beds, Northern Virginia private hospitals may reduce their maximum capacity to 156 private adult beds in the near future.
 - Private providers, facing increased challenges in serving persons who have intense or complex service needs, are unable to serve some persons
- The capacity at the Northern Virginia Mental Health Institute (NVMHI) remains at 127 beds. Most of the time NVMHI is full or near capacity.
 - About 25% of the people in NVMHI could be served in the community if housing and integrated services were available.

A large and increasing percentage of psychiatric patients in private hospitals have no hospital psychiatric services. In addition, about one-third of the patients admitted to upon discharge. As a result, their hospital stays are sometimes longer than necessary moderate income, uninsured individuals and do not seek reimbursement. The large patients are treated as charity care - where hospitals provide free service to low to charity care levels, combined with a relatively low percentage of persons who are private hospitals and three-fourths of the patients at NVMHI have no place to go privately insured, place a significant strain on the financial operations of private insurance coverage for their hospitalization. Without funds to pay for services,

meet the demand for impatient care: by diverting consumers to community programs; by increasing psychiatric bed capacity for those who need this intensive service; and Iwo work groups - Mental Health and Private Hospitals - are reviewing options to by offering suitable discharge plans

Not Guilty by Reason of Insanity Forensic Services and

In Northern Virginia, if a person with mental illness is arrested, he may receive some service depends upon the person's condition and whether the person Northern Virginia Mental Health Institute (NVMHI). The type and location of the mental health services at the local jail, at Western State Hospital (WSH) or the has already been to trial.

to stand trial or of his state of mind when he committed the crime. Following the evaluation and/or treatment, the individual is returned to the local jail. Last year, 142 illness. Sometimes, too, an individual is sent to WSH for an evaluation of his ability being convicted. If, however, the individual's psychiatric symptoms are too severe, people from the local jails in Northern Virginia received some type of mental health Each year, some persons with mental illness are arrested and taken to local jails. Some receive mental health services in the local jail while awaiting trial or after the person may be taken from the jail to WSH to receive treatment for a mental service from WSH. Another group of people who become involved with both the criminal justice system amount of time it takes a patient to move through this graduated program varies but typically exceeds one year and may take several years. NGRI patients currently make progress toward recovery supports his ability to advance through a graduated release program. This program allows greater levels of hospital and community access, with and the public psychiatric hospitals are those Northern Virginia residents who have gone to trial for a crime and have been found Not Guilty by Reason of Insanity (NGRD. Following their trial and adjudication, many of these individuals receive treatment for their mental illness at NVMHI. During treatment, the individual's less supervision, as the individual works toward community reintegration. The up approximately one-fourth of the patient population at NVMHI.

issues related to the treatment of NGRI patients. Their work, along with comments patients, a forensics work group comprised of CSB and NVMHI staff as well as a publish a workbook for all potential and current NGRI patients that explains in a patient representative examined the reasons for the long length of stay and other training, and employment opportunities; increased attention to substance abuse issues; and recommendations for statewide public policy. One suggestion is to from several NGRI patients at NVMHI, resulted in suggestions for education, Concerned that such a large number of NVMHI beds were needed for NGRI quick and easy way the NGRI system, patient rights and their recourses.

Our Vision for Mental Health Services

Development of a cost-effective, comprehensive, culturally competent array of recovery oriented, consumer choice driven integrated services that are flexible and accessible to consumers and oriented toward proactive care, maintaining stability, and maximizing independence and community integration. Education must be intensified to combat and overcome discrimination historically associated with mental illness.

Appendix C - Members of Work Groups

Steering Committee

Co-Chairs

Lynn DeLacy, Northern Virginia Mental Health Institute James A. Thur, Fairfax-Falls Church Community Services Board

Members

Jane Anthony, Parents and Associates of the Institutionalized Retarded

George Barker, Health Systems Agency of Northern Virginia

Mary Ann Beall, Mental Health Consumers Association

John Beghtol, Western State Hospital

Roger Birabin, Loudoun Community Services Board

Ray Bridge, Laurie Mitchell Employment Center/Northern Virginia Mental Health Consumers Association

Mary Burger, Loudoun Community Services Board

Jessica Burmester, Fairfax-Falls Church Community Services Board

Mark Diorio, Northern Virginia Training Center

Tom Geib, Prince William Community Services Board

Mike Gilmore, Alexandria Community Services Board

Amanda Goza, Northern Virginia Mental Health Institute

Wendy Gradison, Psychiatric Rehabilitation Services, Inc.

Betsy Greer, Arlington Community Services Board/Arlington Alliance for the Mentally III

Joe Hinshaw, Northern Virginia Mental Health Institute Advisory Board

Sharon Jones, Fairfax-Falls Church Community Services Board

Leslie Katz, Northern Virginia Training Center

Henriette Kellum, Arlington Community Services Board

Cindy Kemp, Arlington Community Services Board

Edwin H. Kline, Sr., Northern Virginia Mental Health Institute

Cathy Pumphrey, Fairfax-Falls Church Community Services Board

Lou Rosato, Northern Virginia Mental Health Institute

Carol Urlich, National Alliance for the Mentally III-Northern Virginia

Leslie Weisman, Arlington Community Services Board

Alan Wooten, Fairfax-Falls Church Community Services Board

L. William Yolton, National Alliance for the Mentally III-Northern Virginia

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Mental Health Work Group

Chair

Leslie Weisman, Arlington Community Services Board

Members

George Barker, Health Systems Agency of Northern Virginia Roger Biraben, Loudoun Community Services Board Joe Bullock, Arlington Community Services Board Caroline Csongos, Northern Virginia Mental Health Institute Lynn DeLacy, Northern Virginia Mental Health Institute Kay Dicharry, Loudoun Community Services Board Mark Diorio, Northern Virginia Training Center Rosanne Faust, Fellowship Health Resources, Inc. Sally Garrett, Northern Virginia Mental Health Institute Amanda Goza, Northern Virginia Mental Health Institute Wendy Gradison, Psychiatric Rehabilitation Services, Inc. Alfred L. Head, Northern Virginia Mental Health Institute Sharon W. Hoover, Prince William Community Services Board Sharon Jones, Fairfax-Falls Church Community Services Board Jennifer Kane, Northern Virginia Mental Health Institute Leslie Katz, Northern Virginia Training Institute Jim Kelly, Fairfax-Falls Church Community Services Board Henriette Kellum, Arlington Community Services Board Cindy Kemp, Arlington Community Services Board Edwin H. Kline, Northern Virginia Mental Health Institute Carol Layer, Alexandria Community Services Board Sharon Letourneau, Northern Virginia Mental Health Institute Laurence R. Levine, Northern Virginia Mental Health Institute Walt Mahoney, Arlington Community Services Board Joel McNair, Pathway Homes, Inc.

Marilyn Pasley, Arlington Community Services Board

Russell Payne, Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

Rita Romano, Prince William Community Services Board Lou Rosato, Northern Virginia Mental Health Institute Kerrie Shrewsbury, Northern Virginia Mental Health Institute James Thur, Fairfax-Falls Church Community Services Board Carol Ulrich, National Alliance for the Mentally III-Northern Virginia Rev. L. William Yolton, National Alliance for the Mentally III-Northern Virginia

Individuals with Co-Occurring Mental Retardation/Mental Illness Work Group

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Private Psychiatric Hospitals Work Group

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George Barker, Health Systems Agency of Northern Virginia
Roger Biraben, Loudoun Community Services Board
Sandy Burns, Potomac Hospital
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Davina Flynn, Northern Virginia Community Hospital
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Amanda Goza, Northern Virginia Mental Health Institute
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Sharon Jones, Fairfax-Falls Church Community Services Board
Vik Khot, MD, Prince William Hospital
L. Jean Reynolds, Dominion Hospital/Northern Virginia Community Hospital
Rita Romano, Prince William Community Services Board
Gail Sullivan, Fairfax-Falls Church Community Services Board
Carol Ulrich, NAMI-Northern Virginia
H. Patrick Walters, Inova Health System
Leslie Weisman, Arlington Community Services Board

Structural Work Group

Chair

Cindy Kemp, Arlington Community Services Board

Members

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Mike Gilmore, Alexandria Community Services Board
Dean Bonney, Arlington Community Services Board
Mary Burger, Loudoun Community Services Board
Jessica Burmester, Fairfax-Falls Church Community Services Board
Jim Thur, Fairfax-Falls Church Community Services Board
Stephanie Foran, Loudoun Community Services Board
Roy Coffey, Prince William Community Services Board
Tom Geib, Prince William Community Services Board
Lynn DeLacy, Northern Virginia Mental Health Institute
Mary Ann Beall, Mental Health Consumers Association

Appendix D - Psychiatric Beds as of April 2004

Service Area	l B		Number of Beds Operated for Adults as of April 2004	Number of Beds Operated for Children & Adolescents as of April 2004	Number of Beds Proposed to be Closed		Number of Beds Proposed to be Added/ Reopened		Currently Operating Adult	Currently operating C & A beds / Max C & A beds in
		Total Number of Licensed Beds as of Hospital April 2004			Adult	Children	Adult	Children	beds / Max Adult Beds in Service Area if all proposed changes occur	Service Area if all proposed changes occur
Alexandria	Inova Alexandria	19	19		19 (Fall 04)				19/ 0	0/ 0
Arlington	Northern Virginia Community	20	20		20 ¹				40/ 40	0/ 0
	Virginia Hospital Center	40	20 ²				20 ²			
Fairfax-	Dominion	100	50	50	50 ¹	50 ¹			107/ 64	50/ 0
Falls	Inova Fairfax	34	34							
Church	Inova Mount Vernon	23	23				7 (Fall 04)			
Loudoun	Loudoun	22	22				,		22/ 22	
	HCA in Broadlands							40 ³		0/ 40
Prince William	Potomac	12	12		12 (Fall 04)				36-44/ 24-32	2-8/ 0-8
	Prince William	32	24-32	0-8						
Total Private	e Beds	302	224-232	50-58	101	50	27	40	224-232/ 150-158	50-58/ 40-48
Northern Virginia	NVMHI	129	129							

¹ Closure linked to opening of new HCA hospital in Broadlands.

² Virginia Hospital Center will not return to their licensed capacity of 40 beds until late in 2004 or early 2005 depending on renovations.

³ The HCA hospital proposed for Broadlands still needs approval from Loudoun County and will take several years to build.